MDR Tracking Number: M5-04-3491-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 06-14-04. Dates of service 04-03-03 through 06-12-03 were not timely filed per Rule 133.308(e)(1) and therefore will not be reviewed by the Medical Review Division.

The IRO reviewed office visits, office visits with manipulation, prolonged evaluation, hot/cold pack therapy, electrical stimulation, ultrasound therapy, massage therapy, manual therapy technique, FCE and aquatic therapy rendered from 06-25-03 through 02-10-04 that were denied based upon "U" and "V".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-15-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
07-01-03 through 01-22-04 (11 DOS)	99080-73	$165.00 (1 unit @ $15.00 X 11 DOS)	$0.00	U	$15.00	Rule 133.106(f)	The services denied with denial code U. The service is a TWCC required work status report, therefore the services are reviewed as fee issues. Reimbursement is recommended in the amount of $15.00 X 11 DOS = $165.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
07-15-03	99213	$48.00 (1 unit)	$0.00	NO EOB	$48.00	96 MFG E/M GR (VI)(B)	The requestor nor respondent raised any denial reason. Reimbursement is recommended in the amount of $48.00
12-30-03	99213	$61.00 (1 unit)	$0.00	NO EOB	$59.00	Rule 134.202(b)	The requestor nor respondent raised any denial reason. Reimbursement is recommended in the amount of $59.00
08-26-03	97140	$43.00 (1 unit)	$0.00	NO EOB	$30.90	Rule 134.202(b)	The requestor nor respondent raised any denial reason. Reimbursement is recommended in the amount of $30.90
TOTAL		$317.00	$0.00				Requestor is entitled to reimbursement in the amount of $302.90

This Findings and Decision is hereby issued this 1st day of September 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 06-25-03 through 02-10-04 in this dispute.

This Order is hereby issued this 1st day of September 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

August 25, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3491-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 51 year-old male who sustained a work related injury on ------. The patient reported that while at work he injured his right hip moving concrete forms. A MRI of the right hip performed on 9/6/02 was reported to have shown avascular necrosis of the right femoral head with 50 percent involvement and some flattening of the femoral head. The diagnoses for this patient have included aseptic necrosis femur head/neck, osteoarthritis NOS and lumbar IVD. Initially the patient was referred for aquatic therapy. On 11/5/02 the patient underwent a procedure where several holes were drilled into the head of the right femur. A repeat MRI of the right hip performed on 6/26/03 showed evidence of core decompression right femoral head and neck associated with an area of avascular necrosis with abnormal bone marrow signal intensity edema. The patient was then treated with electrical muscle stimulation, ultrasound, massage, hot pack on the lumbar region to reduce muscle spasm and to restore normal spinal biomechanics, and joint mobilization.

Requested Services

Office visit 99213, office visit with manipulation 99213-mp, prolonged eval 99358, hot/cold pack 97010, electrical stimulation 97032, ultrasound 97035, massage 97124, manual therapy technique 97140, FCE 97750 and aquatic therapy 97113 from 6/25/03 – 2/10/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. MMI 4/29/04
2. Office notes 4/1/03 – 7/15/03
3. Workers Compensation Initial Evaluation Report 4/1/03
4. Progress notes 6/18/03 – 1/26/04
5. MRI report 6/26/03
6. Orthopedic Office notes 9/11/02 through 2/26/03
7. Patient Daily Progress notes 7/23/03 – 6/28/04

Documents Submitted by Respondent:

1. Required Medical Exam 5/6/03
2. Same as above

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a 51 year-old male who sustained a work related injury to his right him on ------. The ------ chiropractor reviewer also noted that treatment for this patient's condition had included electrical muscle stimulation, ultrasound, massage, hot pack on the lumbar region to reduce muscle spasm and to restore normal spinal biomechanics, and joint mobilization. The ------ chiropractor reviewer indicated that when a patient sustains a biomechanical injury such as this one, other areas of the body and spine often compensate for the injured body part. The ------ chiropractor reviewer explained that this patient would require future treatment and possible surgery. The ------ chiropractor reviewer also explained that the patient responded well to the treatment rendered. Therefore, the ------ chiropractor consultant concluded that the office visit 99213, office visit with manipulation 99213-mp, prolonged eval 99358, hot/cold pack 97010, electrical stimulation 97032, ultrasound 97035, massage 97124, manual therapy technique 97140, FCE 97750 and aquatic therapy 97113 from 6/25/03 – 2/10/04 were medically necessary to treat this patient's condition.

Sincerely,